		FOR OHF USE					

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042135

Facility Name: Bethany Health Care & Rehab Center

Address: 3298 Resource Parkway (Number) Dekalb (City) 60115 (Zip Code)

County: Dekalb

Telephone Number: (815) 756-5526 **Fax #** ( )

IDPA ID Number: 43-1776735

Date of Initial License for Current Owners: 1/28/1998

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Ken Marx, BKD, LLP **Telephone Number:** (314) 231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name) Clark Ribordy, THCSLLC, Mgt. Co.
(Title)

Paid Preparer
(Signed) (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	90	Skilled (SNF)	90	32,850	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	90	TOTALS	90	32,850	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	13,592	8,632	6,388	28,612	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,592	8,632	6,388	28,612	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 87.10%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A - None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/04/1997

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/4/1997 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 90 and days of care provided 6,388

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	211,325	6,276	11,091	228,692		228,692	(1,169)	227,523			1
2	Food Purchase		147,795		147,795		147,795	(768)	147,027			2
3	Housekeeping		6,559	91,448	98,007		98,007		98,007			3
4	Laundry		16,344	60,966	77,310		77,310		77,310			4
5	Heat and Other Utilities			123,708	123,708		123,708		123,708			5
6	Maintenance	32,583	16,978	72,851	122,412		122,412		122,412			6
7	Other (specify):*											7
8	**TOTAL General Services**	243,908	193,952	360,064	797,924		797,924	(1,937)	795,987			8
	B. Health Care and Programs											
9	Medical Director			11,712	11,712		11,712		11,712			9
10	Nursing and Medical Records	1,445,781	96,273	10,162	1,552,216		1,552,216		1,552,216			10
10a	Therapy	420	2,114	359,774	362,308		362,308		362,308			10a
11	Activities	59,493	2,213	6,419	68,125		68,125		68,125			11
12	Social Services	57,665		3,405	61,070		61,070		61,070			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,563,359	100,600	391,472	2,055,431		2,055,431		2,055,431			16
	C. General Administration											
17	Administrative	82,213	(287)		81,926		81,926		81,926			17
18	Directors Fees											18
19	Professional Services			265,546	265,546		265,546		265,546			19
20	Dues, Fees, Subscriptions & Promotions			53,092	53,092		53,092	(21,532)	31,560			20
21	Clerical & General Office Expenses	129,420	32,331	36,143	197,894		197,894	(69,997)	127,897			21
22	Employee Benefits & Payroll Taxes			279,536	279,536		279,536		279,536			22
23	Inservice Training & Education			4,595	4,595		4,595		4,595			23
24	Travel and Seminar			9,656	9,656		9,656		9,656			24
25	Other Admin. Staff Transportation			2,818	2,818		2,818		2,818			25
26	Insurance-Prop.Liab.Malpractice			97,187	97,187		97,187		97,187			26
27	Other (specify):*											27
28	**TOTAL General Administration**	211,633	32,044	748,573	992,250		992,250	(91,529)	900,721			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,018,900	326,596	1,500,109	3,845,605		3,845,605	(93,466)	3,752,139			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bethany Health Care & Rehab Center #0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			128,377	128,377		128,377		128,377			30
31	Amortization of Pre-Op. & Org.			9,238	9,238		9,238	(9,238)				31
32	Interest			397,276	397,276		397,276	(2,946)	394,330			32
33	Real Estate Taxes			107,000	107,000		107,000		107,000			33
34	Rent-Facility & Grounds							8,035	8,035			34
35	Rent-Equipment & Vehicles			1,975	1,975		1,975	1,544	3,519			35
36	Other (specify):*											36
37	**TOTAL Ownership**			643,866	643,866		643,866	(2,605)	641,261			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		206,561	31,803	238,364		238,364		238,364			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			51,397	51,397		51,397		51,397			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		206,561	83,200	289,761		289,761		289,761			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,018,900	533,157	2,227,175	4,779,232		4,779,232	(96,071)	4,683,161			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,169)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,946)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(768)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(100)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(23,583)	21		24
25	Fund Raising, Advertising and Promotional	(21,532)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,287)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (51,385)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(9,238)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(35,448)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (44,686)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (96,071)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Bethany Health Care & Rehab Center

ID# 0042135

Report Period Beginning: 1/1/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Miscellaneous Income	$ (1,287)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,287)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,169)	0	0	0	0	0	0	0	0	0	0	(1,169)	1
2	Food Purchase	(768)	0	0	0	0	0	0	0	0	0	0	(768)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,937)	0	0	0	0	0	0	0	0	0	0	(1,937)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(21,532)	0	0	0	0	0	0	0	0	0	0	(21,532)	20
21	Clerical & General Office Expenses	(24,970)	(45,027)	0	0	0	0	0	0	0	0	0	(69,997)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(46,502)	(45,027)	0	0	0	0	0	0	0	0	0	(91,529)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(48,439)	(45,027)	0	0	0	0	0	0	0	0	0	(93,466)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Bethany Health Care & Rehab Center** **#** **0042135** **Report Period Beginning:** **1/1/2004** **Ending:** **12/31/2004**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	**5 & 5A**	**6**	**6A**	**6B**	**6C**	**6D**	**6E**	**6F**	**6G**	**6H**	**6I**	**TOTALS (to Sch V, col.7)**	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(9,238)	0	0	0	0	0	0	0	0	0	0	(9,238)	31
32	Interest	(2,946)	0	0	0	0	0	0	0	0	0	0	(2,946)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,035	0	0	0	0	0	0	0	0	0	8,035	34
35	Rent-Equipment & Vehicles	0	1,544	0	0	0	0	0	0	0	0	0	1,544	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,184)	9,579	0	0	0	0	0	0	0	0	0	(2,605)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(60,623)	(35,448)	0	0	0	0	0	0	0	0	0	(96,071)	45

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Tutera Health Care Services, LLC'	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Building and Fixtures	$	Tutera Health Care Services, Inc	100.00%	$ 8,035	$ 8,035	1
2	V	35	Moveable Equipment		Tutera Health Care Services, Inc	100.00%	1,544	1,544	2
3	V	21	Non-Capital	211,177	Tutera Health Care Services, Inc	100.00%	166,150	(45,027)	3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 211,177			$ 175,729	$ * (35,448)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Tutera Health Care Services, LLC
Street Address: 7611 State Line Road, Suite 301
City / State / Zip Code: Kansas City, MO 64114
Phone Number: (816) 444-0900
Fax Number: (816) 822-1723

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Non-Capital	Direct Cost	126,282,310	47	$ 5,217,777	$	4,021,253	$ 166,152	1
2	34	Capital Building	Direct Cost	126,282,310	47	252,330		4,021,253	8,035	2
3	35	Capital Equipment	Direct Cost	126,282,310	47	48,489		4,021,253	1,544	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 5,518,596	$		$ 175,731	25

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	WMF Huntoon		X	Mortgage	Monthly	7/1/1997	$ 3,645,000	$ 3,519,737		0.0850	$ 379,051	1
2	CAMBRIDGE REALTYY		X	Note payable	Monthly	4/12/2000	898,100	876,310		0.0825	18,225	2
3												3
4												4
5												5
	Working Capital											
6	Interest Income		X								(2,946)	6
7												7
8												8
9	TOTAL Facility Related						$ 4,543,100	$ 4,396,047			$ 394,330	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 4,543,100	$ 4,396,047			$ 394,330	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Bethany Health Care & Rehab Center **#** 0042135 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$ 104,430	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$ 102,328	2
3. Under or (over) accrual (line 2 minus line 1).	$ (2,102)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$ 109,102	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$ 107,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999	98,335	8
2000	155,350	9
2001	104,431	10
2002	106,158	11
2003	104,430	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Bethany Health Care & Rehab Center COUNTY Dekalb

FACILITY IDPH LICENSE NUMBER 0042135

CONTACT PERSON REGARDING THIS REPORT Junior Foster, THCSLLC, Mgmt Co.

TELEPHONE (816) 444-0900 FAX #: (816)822-1723

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 37,083 B. General Construction Type: Exterior Face Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 100,136
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 9,238
4. Dates Incurred: Various

Nature of Costs: See Fixed Asset Schedule
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	37,083	1997	$ 303,889	1
2					2
3	TOTALS	37,083		$ 303,889	3

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	90		1997	1997	$ 3,472,204	$ 83,680	40	$ 83,680	$	$ 634,731	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	1997 Additions			1997	430,437	4,098	Varies	4,098		139,448	9
10	1998 Additions			1998	77,700	213	Varies	213		17,298	10
11	1999 Additions			1999	16,507	1,184	Varies	1,184		6,887	11
12	2000 Additions			2000	6,556	591	Varies	591		2,662	12
13	Removal of Asphalt, Excavate Gravel, & Pave			2001	2,450	306	8	306		970	13
14	Door Alarm System			2001	4,951	330	15	330		1,293	14
15	Floor Strips (between carpet and tile)			2001	763	76	10	76		286	15
16	Door Alarm Upgrade			2001	1,654	110	15	110		395	16
17	Keypads for Alarm System (7)			2001	3,597	360	10	360		1,169	17
18	Replaced Monitor			2001	989	99	10	99		313	18
19	Clean and Seal Parking Lot			2002	2,140	268	8	268		646	19
20	Soft Water Mineral Tank			2002	900	90	10	90		255	20
21	Compressor for A/C Unit			2002	1,011	67	15	67		163	21
22	Satin Doors and Trim for Res Rms and Common Rms			2002	500	100	5	100		242	22
23	Electric Heat A/C Unit			2003	1,013	101	10	101		144	23
24	Storage Sheds (2)			2003	3,015	151	20	151		176	24
25	Heat Lamps in Shower Room			2003	3,648	365	10	365		426	25
26	Hallway Carpet			2003	7,802	1,561	5	1,561		3,121	26
27	Rooftop A/C Unit			2004	5,175	302	10	302		302	27
28	Wanderguary system for front door			2004	1,617	54	10	54		54	28
29	Nurse station			2004	11,453	127	15	127		127	29
30	2004 Audit Adjestment			2004		1,431		1,431			30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,056,082	$ 95,664		$ 95,664	$	$ 811,108	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 369,809	$ 29,031	$ 29,031	$	Varies	$ 312,785	71
72	Current Year Purchases	45,693	3,682	3,682		Varies	3,682	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 415,502	$ 32,713	$ 32,713	$		$ 316,467	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,775,473	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 128,377	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 128,377	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,127,575	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. 0
This amount was calculated by dividing the total amount to be amortized 0
by the length of the lease 0 .

9. Option to Buy: [ ] YES [X] NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [X] YES [0] NO

16. Rental Amount for movable equipment: $ 1,975 Description: See attached detail
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	3,107	$	139,295	$	3,107	$ 139,295	1
2	Licensed Speech and Language Development Therapist		hrs		89		11,816		89	11,816	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs		2,346		208,584		2,346	208,584	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	5,542	$	359,695	$	5,542	$ 359,695	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Bethany Health Care & Rehab Center **#** 0042135 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2004 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 68,021	$	1
2	Cash-Patient Deposits	5,270		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	822,083		3
4	Supply Inventory (priced at)	18,337		4
5	Short-Term Investments			5
6	Prepaid Insurance	34,955		6
7	Other Prepaid Expenses	280,026		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from LOC Lender	208,391		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,437,083	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	303,889		13
14	Buildings, at Historical Cost	3,622,604		14
15	Leasehold Improvements, at Historical Cost	4,590		15
16	Equipment, at Historical Cost	415,502		16
17	Accumulated Depreciation (book methods)	(1,127,573)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	373,243		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(46,859)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,545,396	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,982,479	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 130,856	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,270		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	54,910		30
31	Accrued Taxes Payable (excluding real estate taxes)	134,521		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	25,077		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	25,168		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 375,802	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	882,374		39
40	Mortgage Payable	3,519,737		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,402,111	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,777,913	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 204,566	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,982,479	$	48

***(See instructions.)**

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 72,931	1
2	Restatements (describe):		2
3	**Restatements of Prior Year to allow Rollforward**	(36,099)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 36,832	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	167,734	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 167,734	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 204,566	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,949,556	1
2	Discounts and Allowances for all Levels	(458,525)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,491,031	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	957,743	6
7	Oxygen	2,510	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 960,253	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,169	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	414,889	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	32,376	19
20	Radiology and X-Ray		20
21	Other Medical Services	43,014	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 491,448	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	2,946	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,946	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	1,288	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,288	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,946,966	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	797,924	31
32	Health Care	2,055,431	32
33	General Administration	1,043,647	33
	B. Capital Expense		
34	Ownership	643,866	34
	C. Ancillary Expense		
35	Special Cost Centers	238,364	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,779,232	40
41	**Income before Income Taxes (line 30 minus line 40)****	167,734	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 167,734	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	8,559	8,660	$ 223,371	$ 25.79	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,405	12,471	358,715	28.76	3
4	Licensed Practical Nurses	9,163	9,283	283,098	30.50	4
5	Nurse Aides & Orderlies	46,179	46,448	511,607	11.01	5
6	Nurse Aide Trainees	3,516	3,554	42,873	12.06	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides			420		8
9	Activity Director					9
10	Activity Assistants	4,952	5,382	59,492	11.05	10
11	Social Service Workers	3,623	3,719	57,665	15.51	11
12	Dietician	22,051	22,175	211,325	9.53	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	1,982	2,050	32,583	15.89	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,106	2,186	88,881	40.66	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,490	8,531	120,634	14.14	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,976	2,006	28,236	14.08	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	125,002	126,465	$ 2,018,900 *	$ 15.96	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	91	$ 12,088	1,3	35
36	Medical Director				36
37	Medical Records Consultant	88	3,784	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	86	5,141	10,3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	2,298	11,3	44
45	Social Service Consultant				45
46	Other(specify) Housekeeping	5,189	72,651	0	46
47	Laundry	3,371	47,194	0	47
48	Admin/Gen	167	14,487	0	48
49	TOTAL (lines 35 - 48)	9,030	$ 157,643		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	521	$ 18,668	10,3	50
51	Licensed Practical Nurses	718	25,734	10,3	51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	1,239	$ 44,402		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Scott McBride	Admin	0	$ 82,213
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 82,213

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Legal Fees		$ 9,820
Purchased Services		29,985
Data Processing		8,629
Accounting		5,150
Professional Services		785
Management Fees		211,177
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 265,546

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,134
Unemployment Compensation Insurance	
FICA Taxes	166,078
Employee Health Insurance	34,010
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	314
TOTAL (agree to Schedule V, line 22, col.8)	$ 279,536

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	23,431
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	8,129
Advertising & Public Relations	21,532
Less: Public Relations Expense	( )
Non-allowable advertising	(21,532)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 31,560

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	9,656
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,656

**See instructions.

Facility Name & ID Number Bethany Health Care & Rehab Center # 0042135 Report Period Beginning: 1/1/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Bethany Health Care & Rehab Center **#** 0042135 **Report Period Beginning:** 1/1/2004 **Ending:** 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **9**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **15,499** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **51,397**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,169**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **N/A**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **No**
Attach invoices and a summary of services for all architect and appraisal fees.